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# Preliminary Report of the Health Care System and Health Security Board

Maine State Legislature

Office of Policy and Legal Analysis

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**STATE OF MAINE  
120<sup>th</sup> LEGISLATURE  
SECOND REGULAR SESSION**

**Preliminary Report  
of the**

**HEALTH CARE SYSTEM AND  
HEALTH SECURITY BOARD**

**January 15, 2003**

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Representative Paul Volenik, Chair  
Senator Mary E. Small  
Representative Florence T. Young**

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## **Acknowledgements**

The Health Care System and Health Security Board gratefully acknowledges the generous financial award of \$200,000 from the Maine Health Access Foundation, Inc. to support the feasibility study conducted by Mathematica Policy Research, Inc. In addition, the Board raised over \$34,000 from several organizations and individuals, including the Maine State Nurses Association and nurses associations in California, New York, Pennsylvania and Massachusetts; the Maine Chapter of the Association of Certified Nurse Midwives; and the Maine Nurse Practitioners Association. The Board thanks all who have contributed to its efforts.

The Health Security Board also acknowledges the cooperation of the Department of Human Services, Bureau of Medical Services and the Maine Health Management Coalition with providing Maine data for use in the feasibility study. We appreciate their willingness to share this information. The Maine Health Information Center provided technical assistance to the Board and Mathematica Policy Research in analyzing the claims data from the State's MaineCare program and from the Maine Health Management Coalition. Anthem Blue Cross and Blue Shield of Maine also contributed claims data for use in the feasibility study.

## **Executive Summary**

The Health Care System and Health Security Board, hereafter referred to as the Health Security Board or Board, was established in Public Law 2001, chapter 439, Part ZZZ. While the purpose of the Board was to develop recommendations to provide universal access to health care coverage for all Maine citizens, the Health Security Board was specifically required to assess the feasibility and cost of implementing a single-payer health care system in Maine. Such a system would provide universal health care coverage to every Maine resident through a standard benefit plan administered and paid for by a single payer, the State of Maine.

The Health Security Board, chaired by Senator John Martin and Representative Paul Volenik, is a bipartisan task force with 19 members including representatives of both chambers and both major parties within the Legislature, the Department of Human Services, the State Employee Health Commission and the State Tax Assessor and representatives of provider organizations, employers, insurers and advocacy groups. Charlene Rydell, a member of the Maine Health Access Foundation Board of Trustees, provided valuable input and assistance as a liaison from the Foundation to the Board. The Health Security Board was first convened on October 12, 2001 and met more than 20 times throughout 2002.

From its inception, the Health Security Board focused its efforts on its mandate to conduct a feasibility study of the economic impact on individuals and businesses of a single-payer plan that guarantees a minimum 5% savings over existing health care costs and that addresses the potential positive or negative impact of the plan on the State's economy. To meet its mandate, the Board contracted with Mathematica Policy Research, Inc., a national health care consulting firm, to conduct the feasibility study.

The Board asked Mathematica to develop a microsimulation model to project the financial and economic impact of a single-payer health care plan in Maine. Briefly, the microsimulation model developed by Mathematica is comprised of four modules: (1) a population module used to project the demographic and health insurance coverage characteristics; (2) a cost module used to project health care spending by type of service and the source of spending that includes both medical and administrative costs; (3) a financing module used to project current levels of revenue from current and available sources for funding health care expenditures; and (4) an economic impact module used to project the impact of a single-payer health plan on the State's economy and employment. The complete feasibility study prepared by Mathematica, including documentation of the microsimulation model, its assumptions and sensitivity analyses, and its results projecting the costs of a single-payer health plan, is included as an appendix to the full report.

As defined by the Health Security Board, the single-payer health plan would provide health care coverage to all Maine residents through one standard benefit design. Coverage of Maine residents eligible for federally supported programs like Medicare, MaineCare, CHAMPUS and the federal employee plan would be subsumed under the single-payer plan. Federal approval and waivers would be needed to assure continued participation and funding. For use in the feasibility study, the Board developed 3 primary benefit designs:

(1) a benefit plan modeled on MaineCare (Maine's Medicaid program); (2) a benefit plan that requires cost sharing in the form of copayments only for certain services with a cap on out-of-pocket spending; and (3) a benefit plan that requires cost-sharing in the form of copayments and coinsurance for certain services with a cap on out-of-pocket spending. For each of the alternative benefit designs, the Board asked Mathematica to model 3 different cost projections based on income level--- incomes at or below 200%, 300% and 400% of the federal poverty level--- to determine whether cost sharing would be required.

To finance the costs of the single-payer plan, the model developed by the Board assumes that federal and State government funding for health care coverage and the direct provision of health care services would be maintained at its current level. In addition, the model assumes full enrollment of an eligible population for public programs to maximize the federal and State financial contribution. The remaining costs of the single-payer plan would be paid from the State's General Fund either by raising new revenue through targeted taxes or redirecting current tax revenue. An individual or employer's contribution in the form of premiums would be eliminated, although employers and employees might pay into the system through a payroll tax and individuals may be asked to participate through cost sharing with a cap on out-of-pocket spending.

While the Board believes additional time is needed to consider the Mathematica feasibility study and develop final recommendations to the Legislature, the Health Security Board makes these preliminary findings and recommendations:

**The Health Security Board supports universal coverage for all Maine citizens--- every man, woman and child living in this State deserves comprehensive health care coverage.**

**The Health Security Board finds that maintaining the "status quo" for Maine's health care system cannot be sustained.**

**While additional information and further analysis is needed, the Health Security Board finds that a single-payer health care system providing universal coverage appears to be financially feasible.**

**The Health Security Board recommends that the Legislature authorize the Board to continue its work until January 1, 2004 to refine and extend the financial feasibility study and to develop a transition and implementation plan for achieving universal coverage through a single-payer health care system in Maine.**

The rationale for these decisions is explained in the full report.

The Health Security Board hopes that this report and the microsimulation model will provide a foundation for informed and constructive dialogue among policymakers and others interested in reforming Maine's current health care system. The results of the feasibility study suggest that a single-payer health care system appears to be a feasible

approach to achieving universal coverage but more information and analysis is needed. With additional time and resources, the Health Security Board believes it can help develop a blueprint for universal coverage. We look forward to the goal of universal coverage.

## **I. Introduction**

The Health Care System and Health Security Board, hereafter referred to as the Health Security Board or Board, was established in Public Law 2001, chapter 439, Part ZZZ. A copy of the Board's enabling legislation is included as Appendix A. While the purpose of the Board was to develop recommendations to provide universal access to health care coverage for all Maine citizens, the Health Security Board was specifically required to assess the feasibility and cost of implementing a single-payer health care system in Maine. Such a system would provide universal health care coverage to every Maine resident through a standard benefit plan administered and paid for by a single payer, the State of Maine.

The Health Security Board, chaired by Senator John Martin and Representative Paul Volenik, is a bipartisan task force with 19 members including representatives of both chambers and both major parties within the Legislature, the Department of Human Services, the State Employee Health Commission and the State Tax Assessor and representatives of provider organizations, employers, insurers and advocacy groups. The members of the Board and their appointing authorities are as follows:

Members appointed by the President of the Senate:

- **Sen. John L. Martin, Chair**
- **Sen. Mary E. Small**
- **Robert Downs/Victoria Kuhn**, Representing Statewide Organizations of Health Insurers
- **Tammy Greaton**, Representing Statewide Organization Advocating Universal Health Care
- **Beth Kilbreth, PhD**, Representing Health Care Economists\*
- **Marjorie Medd**, Representing Statewide Organizations Defending Rights of Children
- **Leo Siegel, MD**, Representing Small Hospitals in the State
- **Richard Wexler, MD**, Representing Statewide Organizations of Physicians

Members appointed by the Speaker of the House:

- **Rep. Paul Volenik, Chair**
- **Rep. Florence T. Young**
- **James Amaral**, Representing the Business Community



- **Howard Buckley**, Representing Large Hospitals in the State
- **John Moran**, Representing Statewide Senior Citizen's Organizations
- **Frank O'Hara**, Representing Self-employed Persons
- **Patricia Philbrook**, Representing Statewide Organization of Nurses
- **Violet Raymond**, Representing Statewide Labor Organizations, Maine AFLCIO

Appointments required by statute:

- **Frank A. Johnson**, Director, State Office of Employee Health and Benefits
- **Anthony Neves**, State Tax Assessor
- **Christine Zukas-Lessard**, Deputy Director, Bureau of Medical Services, Designee of the Commissioner of Human Services

Charlene Rydell, a member of the Maine Health Access Foundation Board of Trustees, provided valuable input and assistance as a liaison from the Foundation to the Board.

The Health Security Board was first convened on October 12, 2001 and met more than 20 times throughout 2002. Summaries of the Board's meetings are available electronically at [www.state.me.us/legis/opla/hsboardmins.htm](http://www.state.me.us/legis/opla/hsboardmins.htm).

\* Dr. Kilbreth resigned from the Board effective December 31, 2002 because of time constraints related to her role as Project Director for the HRSA-funded Maine State Planning Grant.

### **A. Creation of Health Care System and Health Security Board**

The Health Security Board was created in the Part II budget, Public Law 2001, chapter 439, Part ZZZ. During the First Regular Session of the 120<sup>th</sup> Legislature, the Joint Standing Committee on Banking and Insurance considered several bills proposing the establishment of a single-payer health care system in Maine. The committee also considered 2 bills that proposed the establishment of a study commission to consider the feasibility of a single-payer system and other options for universal coverage. In its consideration of these proposals, the committee reported out 2 legislative proposals with majority reports of "Ought to Pass as Amended": LD 1277, An Act to Establish a Single-payor Health Care System, sponsored by Rep. Paul Volenik, and LD 1490, Resolve, to Establish the Commission to Develop and Finance Health Care Coverage for All Maine People, sponsored by Rep. Christopher O'Neil. When these bills were referred to the House and Senate for further action, differences between the legislative bodies arose as to

their final disposition. LD 1277, An Act to Establish a Single-payor Health Care System, was enacted in the House of Representatives, but was not removed from the Special Appropriations Table in the Senate and died upon adjournment of the First Regular Session of the 120<sup>th</sup> Legislature. LD 1490, Resolve, to Establish the Commission to Develop and Finance Health Care Coverage for All Maine People, died in non-concurrence when the House and Senate could not agree on the appointment of a committee of conference. As a compromise, legislative language to conduct a study of the economic feasibility of a single-payer system and to establish the Health Security Board was added to the Part II budget legislation.

### **B. Health Security Board's Purpose and Duties**

As outlined in the enabling legislation, the purpose of the Health Security Board was “to develop recommendations to provide health care coverage to all citizens of this State through a plan or plans that emphasize 24-hour coverage, quality, cost containment, choice of provider and access to comprehensive, preventive and long-term care.”

In addition, the Board was asked to:

- Examine prior studies in Maine and other States;
- Determine the savings that might be realized from a single-payor health care system by hospitals, schools and correctional facilities and other lines of insurance that pay for health care services, including automobile insurance, general liability insurance and workers' compensation insurance;
- Develop a proposal to implement a single-payer plan and make recommendations related to standards for eligibility, covered benefits and health care services, health care delivery throughout the State, provider participation and reimbursement, and the role of federal health care programs and ERISA plans;
- Examine funding for the single-payor plan from a combination of sources, including payments from government sources, including federal, state and other governmental health care and aid programs; payments from workers' compensation, pension and health insurance employee benefit plans; payments from state, county and municipal governmental units for coverage; payments from tobacco settlement funds; and payments from any taxes or fees;
- Conduct a feasibility study of the economic impacts on individuals and businesses of a single-payor plan that guarantees a minimum 5% savings over existing health care costs and the impact of such a plan on the State's economy;
- Stress prevention of disease and maintenance of health in developing proposals to implement the single-payer plan and attempt to retain and strengthen existing health facilities whenever possible in developing those proposals; and

- Examine any other issues or gather information necessary to fulfill its purpose and duties.

### **C. Report and Legislation**

Originally, the enabling legislation required that the Board submit a report, including any necessary legislation, on or before March 1, 2002. Upon request to the Legislative Council, the Board's reporting deadline was extended to March 3, 2003; a preliminary report was requested by January 15, 2003. Draft legislation to implement the recommendations of the Health Security Board is included in Appendix C.

## **II. Health Security Board's Scope and Focus**

From its inception, the Health Security Board focused its efforts on its mandate to conduct a feasibility study of the economic impact on individuals and businesses of a single-payer plan that guarantees a minimum 5% savings over existing health care costs and that addresses the potential positive or negative impact of the plan on the State's economy. To meet its mandate, the Board contracted with Mathematica Policy Research, Inc., a national health care consulting firm with offices in Washington, D.C., Princeton, NJ and Cambridge, MA, to conduct the feasibility study. The Board chose Mathematica after a competitive bid process that garnered proposals from five prominent national health care consulting firms specializing in economic modeling.

The Board asked Mathematica to develop a microsimulation model to project the financial and economic impact of a single-payer health care plan in Maine. The Board began meeting with Mathematica in early August and held regular meetings and telephone consultations throughout September, October and November. The final report and results were delivered to the Board on December 18, 2002. The results of the feasibility study form the basis for the Board's findings and recommendations.

## **III. Overview of Single-payer Health Plan Model Used in Feasibility Study**

As defined by the Health Security Board, the single-payer health plan would provide health care coverage to all Maine residents through one standard benefit design. The single-payer plan would be paid for by the State and administered by the State, or, in part, by a private entity under contract with the State. Public and private health insurance programs like Medicare, MaineCare, CHAMPUS, federal and state employee plans and individual and group health insurance plans would be subsumed by the single-payer plan. Coverage of Maine residents eligible for federally supported programs would be consolidated assuming approval of waivers from the federal government.

To finance the costs of the single-payer plan, the model developed by the Board assumes that federal and State government funding for health care coverage and the direct provision of health care services would be maintained at its current level. In addition, the

model assumes full enrollment of an eligible population for public programs to maximize the federal and State financial contribution. The remaining costs of the single-payer plan would be paid from the State's General Fund either by raising new revenue through targeted taxes or redirecting current tax revenue. An individual or employer's contribution in the form of premiums would be eliminated, although employers and employees might pay into the system through a payroll tax and individuals may be asked to participate through cost sharing with a cap on out-of-pocket spending.

In consultation with Mathematica, the Board established guidelines for benefit design and cost containment within the single-payer system.

#### **A. Single-payer Health Plan Benefit Designs**

For use in the feasibility study, the Board developed 3 primary benefit designs: (1) a benefit plan modeled on MaineCare (Maine's Medicaid program); (2) a benefit plan that requires cost sharing in the form of copayments only for certain services with a cap on out-of-pocket spending; and (3) a benefit plan that requires cost-sharing in the form of copayments and coinsurance for certain services with a cap on out-of-pocket spending. For each of the alternative benefit designs, the Board asked Mathematica to model 3 different cost projections based on income level--- incomes at or below 200%, 300% and 400% of the federal poverty level--- to determine whether cost sharing in the form of copayments or coinsurance would be required. Depending on the benefit design, the Board asked Mathematica to assume that no cost-sharing would be required for those with incomes at or below 200%, 300% or 400% of the poverty level.

A matrix of the benefit designs is presented as Table 1.

**Table 1. Matrix of Single-Payer Health Plan Benefit Designs.**

Plan-level features	Plan # 1: MaineCare Benefit Package	Plan # 2: Alternative Benefit Design	Plan # 3: Alternative Benefit Design
<b>Income-level Subject to Cost-sharing /No Cost-sharing below income level</b>	None	Plan 2A: 200% FPL; Plan 2B: 300% FPL; or Plan 2C: 400% FPL	Plan 3A: 200% FPL; Plan 3B: 300% FPL; or Plan 3C: 400% FPL
<b>Out-of-Pocket Maximums</b>			
• Individual	None	\$500 annually	\$1000 annually
• Family	None	\$1000 annually	\$2000 annually
<b>Deductibles</b>	None	None	None
<b>Lifetime maximum</b>	None	None	None
<b>Hospital inpatient</b>	\$0 - \$3 per day; \$30 max per month	\$50 per day; \$300 max per admission	\$50 per day; \$300 max per admission
<b>Hospital outpatient/diagnostic, X-ray, Lab</b>	\$0 - \$3 per day; \$30 max per month	\$25 copay	20% coinsurance
<b>Primary Care Provider Visits</b>	Covered in full	\$10 copay	\$10 copay
<b>Specialty Provider Visits</b>	Covered in full	\$20 copay	\$20 copay
<b>Emergency Room</b>	Covered in full	\$50 copay; waived if admitted	\$50 copay; waived if admitted
<b>Mental Health/Substance Abuse Benefits</b>	Covered in full	Parity	Parity
<b>Prescription Drugs</b>			
Copay-generic	\$0-\$2	\$5	\$10
Copay-brand/preferred	\$0-\$3	\$10	\$20
Copay-brand/nonpreferred	\$0-\$3	\$15	\$30
Out-of-pocket maximum (annual)	None	\$200 individual; \$500 family	\$200 individual; \$500 family
<b>Skilled Nursing</b>	Covered in full	\$25 per day; \$150 max per admission	\$25 per day; \$150 max per admission
<b>Home Health Care</b>	Covered in full	\$10 copay	\$10 copay
<b>Durable Medical Equipment</b>	Covered in full	None	20% coinsurance
<b>Long-term Custodial Care</b>	Covered based on current income eligibility requirements	Covered based on current income eligibility requirements	Covered based on current income eligibility requirements
<b>Eyeglasses</b>	\$100 cap every 2 years	\$100 cap every 2 years	25% coinsurance and \$100 cap every 2 years
<b>Included Benefits (not subject to cost-sharing)</b>	Preventive/wellness care, nutritional counseling, smoking cessation, wellness education, cardiac rehab, routine dental care, routine vision care	Preventive/wellness care, nutritional counseling, smoking cessation, wellness education, cardiac rehab, routine dental care, routine vision care	Preventive/wellness care, nutritional counseling, smoking cessation, wellness education, cardiac rehab, routine dental care, routine vision care
<b>Excluded Benefits</b>	Cosmetic, infertility/sex change, routine foot care, custodial care (long-term custodial care included as described above), vision correction surgery (LASIK)	Cosmetic, infertility/sex change, routine foot care, custodial care (long-term custodial care included as described above), vision correction surgery (LASIK)	Cosmetic, infertility/sex change, routine foot care, custodial care (long-term custodial care included as described above), vision correction surgery (LASIK)

Sources: Alternative Benefit Design Matrix, Office of Policy and Legal Analysis, Mathematica Policy Research

## B. Cost Containment Strategies

The Board envisions that overall spending under the single-payer health plan would be administered through a global budget. As a baseline, the Board assumes that provider reimbursement be determined using the DRG (Diagnosis-Related Groups) payment system familiar to hospitals and the RBRVS (Resource-Based Relative Value Scale) payment system familiar to physicians, nurses and other health care practitioners. Ultimately, the reimbursement for providers will be negotiated like all other costs under the single-payer system.

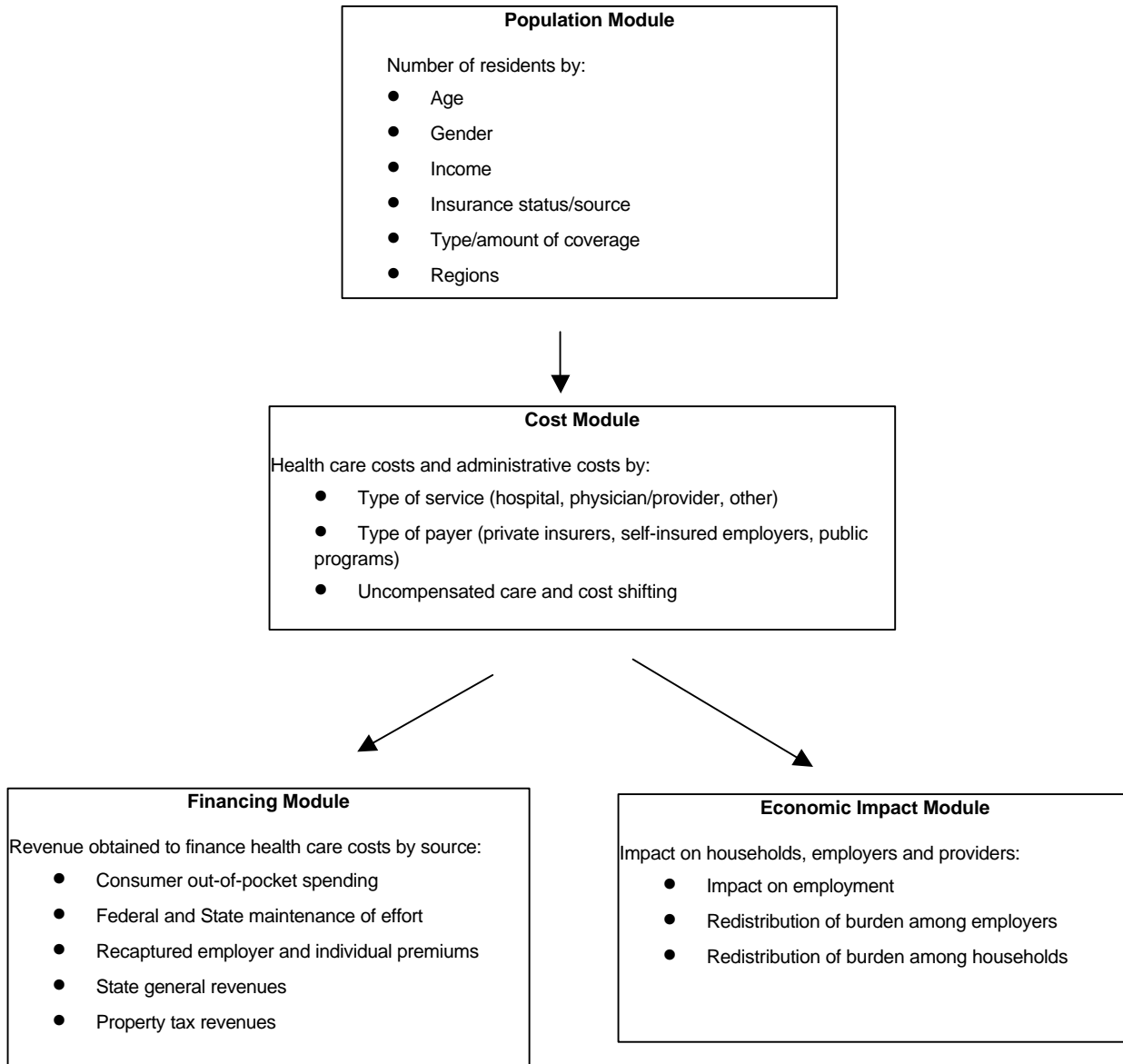
The Board also envisions that the single-payer health plan would utilize certain care management strategies. Currently, the State's MaineCare program uses primary care case management to assist in cost control. The Board directed that the model used by Mathematica assume that primary care case management would continue to be a part of the single-payer health plan. Other care management strategies mentioned in the Board's discussions include risk factor management programs, disease management and care coordination programs, identification and adoption of "best practices" and prior authorization for services using new and emerging technology.

#### **IV. Microsimulation Model Developed by Mathematica**

Briefly, the microsimulation model developed by Mathematica is comprised of four modules: (1) a population module used to project the demographic and health insurance coverage characteristics; (2) a cost module used to project health care spending by type of service and the source of spending that includes both medical and administrative costs; (3) a financing module used to project current levels of revenue from current and available sources for funding health care expenditures; and (4) an economic impact module used to project the impact of a single-payer health plan on the State's economy and employment. The complete feasibility study prepared by Mathematica, including documentation of the microsimulation model, its assumptions and sensitivity analyses, and its results projecting the costs of a single-payer health plan, is included as Appendix B.

Table 2 describes the general design of the microsimulation model; it is a reproduction of Figure III.1 from the Mathematica feasibility study.

**Table 2. Information Flow Diagram for the Maine Microsimulation Model**



## **V. Preliminary Findings and Recommendations**

While the Board believes additional time is needed to consider the Mathematica feasibility study and develop final recommendations to the Legislature, the Health Security Board makes these preliminary findings and recommendations.

**The Health Security Board supports universal coverage for all Maine citizens---every man, woman and child living in this State deserves comprehensive health care coverage.**

Consistent with its purpose, the Health Security Board is unified in the belief that all Maine citizens should have access to comprehensive health coverage that emphasizes preventive care, quality, cost containment, choice of provider and long-term care. Clearly, that is not the case under Maine's current health care system. Based on estimates from the Mathematica study, nearly 96,000 people or 7.4 % of Maine's population will be uninsured in 2004.<sup>1</sup> In addition, the Mathematica study estimates that 22% of those privately insured in the individual market and 11% of those insured by small group employer coverage (2-99 employees) are underinsured.<sup>2</sup> Further, evolving evidence suggests that employers and employees are being faced with double digit premium increases and those cost increases are resulting in an additional erosion of coverage. To the members of the Health Security Board, health coverage is a right of all Mainers. The Health Security Board is committed to ensuring that universal coverage becomes a reality. Soon.

**The Health Security Board finds that maintaining the “status quo” for Maine’s health care system cannot be sustained.**

In 1999, it was estimated that Maine spent about \$5 billion for total health care spending.<sup>3</sup> Without reform, the Mathematica study has projected total spending to increase to \$8.4 billion in 2004, a 37% increase over 2001 spending projections. By 2008, total spending is expected to increase to almost \$11 billion, another increase of over 31%. On a per capita basis, health care spending will account for \$6478 in 2004 and \$8291 in 2008.<sup>4</sup> Over the long term, these cost increases cannot be sustained by any participant in Maine's health care system whether individual citizen, employer, insurer or federal, state or local government. The Health Security Board believes the current system needs reform. Without policy reform, problems of cost and access will continue to escalate and the current health care system will collapse.

**While additional information and further analysis is needed, the Health Security Board finds that a single-payer health care system providing universal coverage appears to be financially feasible.**

In its enabling legislation, the Health Security Board was directed to study the feasibility of a single-payer health plan and develop a plan that achieved a savings of 5% over current

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<sup>1</sup> The estimates used in the Mathematica model of Maine's uninsured population are lower than estimates provided in other published studies that rely on only Current Population Survey (CPS) data from the Census Bureau. In consultation with the Board, Mathematica adjusted the CPS numbers projecting the uninsured population at 11% to account for the fact that the MaineCare population is undercounted in the CPS.

<sup>2</sup> For modeling purposes, “underinsured” has been defined by Mathematica as coverage under a health insurance policy with a deductible of \$2500 or higher.

<sup>3</sup> See “The Cost of Health Care in Maine,” Year 2000 Blue Ribbon Commission on Health Care, Report to Governor Angus S. King, November 2000.

<sup>4</sup> See Mathematica Report, Feasibility of a Single-payer Health Plan Model for State of Maine, Ch. IV.B, p.32 and Table IV.3, p. 35.



spending. The Board interpreted this charge to mean the development of a plan that saved 5% compared to the base line projections for total health care spending in either 2004 or 2008. Based on the results of the Mathematica study, the model's estimates indicate that one plan developed by the Board (plan 3A) will save 2% over base case spending in 2004 and 8% in 2008. Under Plan 3A, individuals would be asked to contribute a maximum of \$1000 and \$2000 annually for individual and family coverage respectively through cost sharing; those individuals or families with incomes at or below 200% of poverty would be exempt from the cost sharing requirement. A more detailed outline of the benefits under Plan 3A is included in Table 1. The model also suggests that even greater savings could be achieved through more aggressive managed care and cost containment strategies, through changes in benefit design or through increased cost sharing requirements.

Further, the financing estimates project that if the current level of public sector effort at the federal and state level is maintained but insurance premiums are discontinued, the total additional financing required for a single-payer system with universal coverage is between \$3.2 and 4.9 billion in 2004 (or 49-52% of the total) depending on the single-payer benefit design. To finance that additional effort in the absence of premium contributions, the Mathematica study uses a payroll tax to model the funding needs for a single-payer system. Depending on the plan's benefit design and cost sharing requirements, the model projects that a payroll tax rate of 11.1% to 16.8% in 2004 and 9.7% to 15.5% in 2008 would provide the necessary funding. Mathematica estimates that private employers currently providing health insurance coverage, on average, contribute approximately 10% of wages and salaries for covered employees in the current premium-based system.<sup>5</sup>

While the Mathematica model suggests a single-payer plan is financially feasible compared to the "status quo", the unanimous endorsement of a single-payer plan by the Health Security Board at this time is premature. There are many complex issues and questions related to the financing, operation and economic impact of a single-payer system that are unresolved. The Health Security Board views the feasibility study conducted by Mathematica with cautious optimism---it suggests that a single-payer health care system may be one feasible approach to achieving universal coverage in Maine.

**The Health Security Board recommends that the Legislature authorize the Board to continue its work until January 1, 2004 to refine and extend the financial feasibility study and to develop a transition and implementation plan for achieving universal coverage through a single-payer health care system in Maine.**

In the Board's opinion, the Mathematica feasibility study provides an excellent foundation to evaluate the likely impact of a single-payer health care system on health care spending and financing in Maine. It also provides an initial assessment of how a single-payer system will affect Maine's economy. However, the microsimulation model has limitations that would benefit from additional analysis and refinement. In addition, the model and the feasibility study does not address many practical and policy issues affecting the operation

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<sup>5</sup> See Mathematica study, Chapter IV. C, p. 43.

of a single-payer system. The Health Security Board believes it is critically important to evaluate these issues before making its final recommendations to the Legislature.

In relation to the microsimulation model, the Health Security Board has identified these unanswered questions:

- What is the economic impact of an alternative financing strategy, which requires broad participation and is more progressive than the current premium system? Does a financing mechanism with these features make Maine a more or less attractive place to do business?
- Can the model's estimates of the financing and economic impact of a single-payer system be integrated?
- Can the distributional impact on Maine's businesses and individuals be modeled?
- Can the model's estimates be improved by incorporating updated population data?
- Can the administrative cost savings assumptions for plans and providers be refined to reflect current costs and experience of Maine plans and providers?
- What is the potential for "adverse selection" through in migration of residents from other states if Maine establishes a single-payer plan? What is the potential for out migration if individuals, businesses and providers leave Maine? What financial impact could that have on the State? What impact would the loss of providers, especially specialty providers, have on the delivery and quality of health care?
- How well does the Watson Wyatt PreView™ model predict Maine's health care costs when applied retroactively?
- How do the single-payer benefit designs used in the model compare with current benefit packages offered by large and small employers?
- What level of financial reserves would be required for implementation of a single-payer plan?
- What are the costs of a transition to a single-payer system?

With regard to the transition to a single-payer health care system, the Health Security Board has not fully addressed all of the operational and policy issues. The Board has discussed many of these issues to some extent, but has not been able to reach consensus as a group. The unresolved questions that need further discussion and consideration by the Health Security Board include but are not limited to:

- What steps are necessary to transition from the current health care system to a single-payer system? How will the costs of transition be paid? What is the timeline necessary for transition? Should coverage under a single-payer system be phased in for certain coverage groups or populations?
- How will a single-payer system be governed? What entity will oversee and administer a single-payer system? How will that entity be structured? Will administration of the system be performed by state government or by contracting with a private entity?
- Can federal maintenance of effort be achieved? What steps are necessary to obtain necessary waivers?

- How will eligibility for coverage under a single-payer system be determined? What standards will be used?
- How will the global budget for a single-payer system be prepared? How will it work? Is there a role for certificate of need?
- How will providers participate in a single-payer system? How will they be reimbursed? At what level? Can regional differences in the cost of health care technology and procedures, for example, between Maine and Massachusetts, be addressed?
- How will the adequacy of a provider network be evaluated? Can the current supply of providers in Maine meet an anticipated increased demand for services?
- What mechanisms can be used to evaluate and ensure the quality of health care services provided under a single-payer plan?
- What health care services will be provided? Will rationing of services be necessary?
- What specific benefit design should be recommended?
- How should a single-payer system be financed? Through a payroll tax? Through a combination of payroll and other taxes?

Without additional time to consider these issues, the Health Security Board cannot adequately meet its charge from the Legislature. An extension will allow the Board time to thoughtfully consider and evaluate the work done by Mathematica. It will allow the Board time to completely respond to the questions outlined above. It will allow the Board time to coordinate its effort with the research and analysis being done on comprehensive system reform through the federally funded state health planning grant. Most importantly, it will allow the Board time to solicit public comment and input on the feasibility study and the work it has completed to date. If additional time is available, the Board plans to schedule public hearings throughout the State and to seek additional funding for consultative expertise. The Board also intends to draft legislation to implement its recommendations for consideration by the 121<sup>st</sup> Legislature.

## **Conclusion**

The Health Security Board hopes that this report and the microsimulation model will provide a foundation for informed and constructive dialogue among policymakers and others interested in reforming Maine's current health care system. The results of the feasibility study suggest that a single-payer health care system appears to be a feasible approach to achieving universal coverage but more information and analysis is needed. With additional time and resources, the Health Security Board believes it can help develop a blueprint for universal coverage. We look forward to reaching the goal of universal coverage.